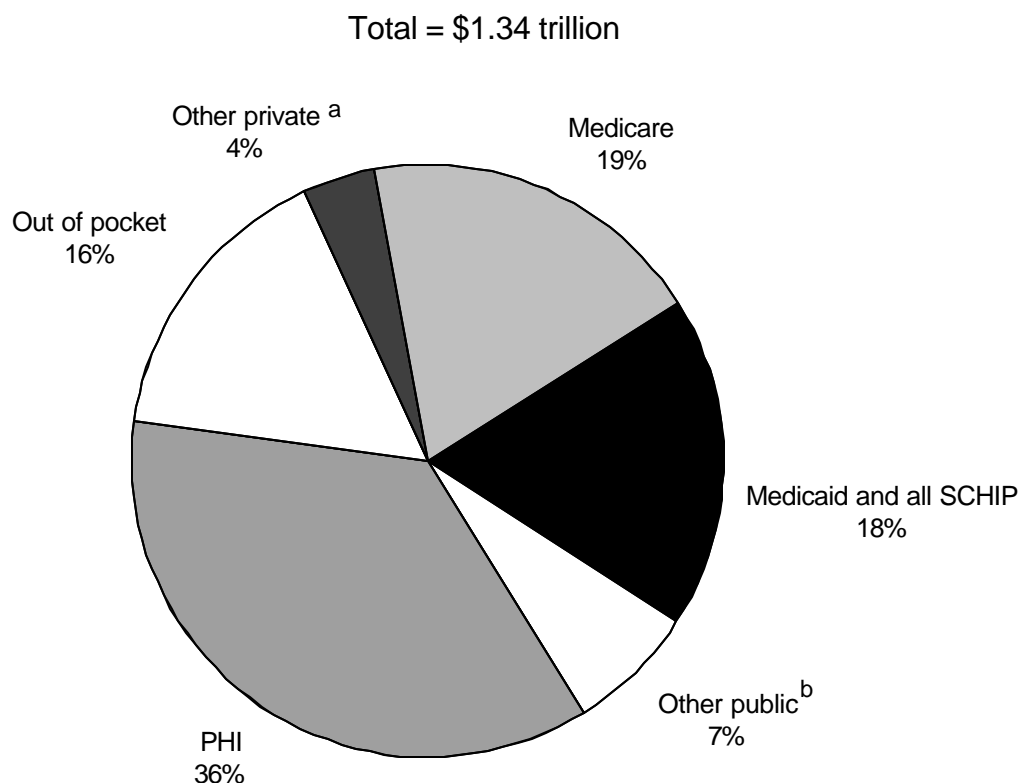


S E C T I O N

6

National health care and Medicare spending

Chart 6-1. Medicare made up about one-fifth of spending on personal health care in 2002

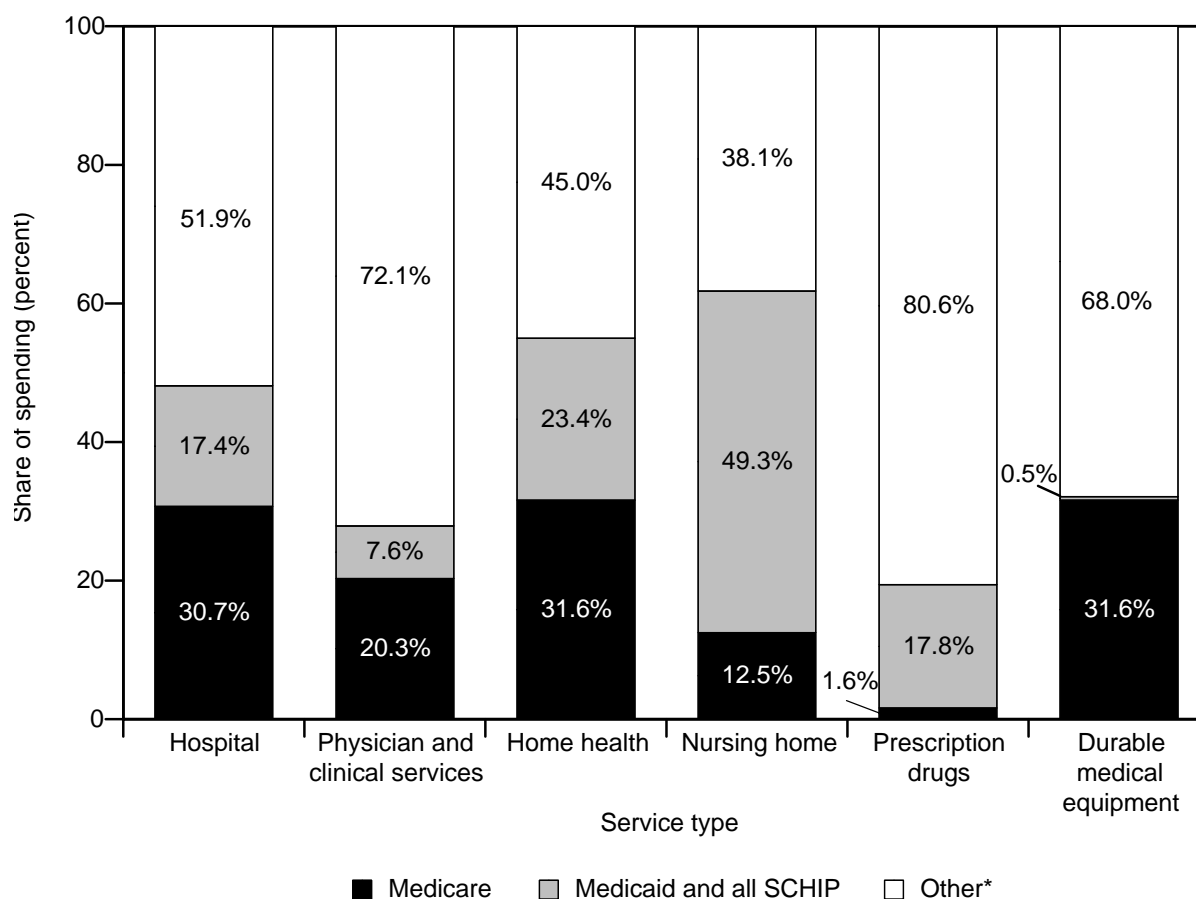


Note: PHI (private health insurance), SCHIP (State Children's Health Insurance Program). Out-of-pocket spending includes cost sharing for both privately and publicly insured individuals. Personal health spending includes spending for clinical and professional services received by patients. It excludes administrative costs and profits.
^a Includes industrial in-plant, privately funded construction, and nonpatient revenues, including philanthropy.
^b Includes programs such as workers' compensation, public health activity, Department of Defense, Department of Veterans Affairs, Indian Health Service, and state and local government hospital subsidies and school health.

Source: CMS, Office of the Actuary, National Health Accounts, 2004.

- Of the \$1.34 trillion spent on personal health care in the United States, Medicare accounts for about 19 percent or \$259 billion. Spending by all public programs, including Medicare, Medicaid, SCHIP, and other programs, accounts for 44 percent of health care spending. Medicare is the largest single purchaser of health care in the United States. Thirty-six percent of spending is from private health insurance payers and 16 percent is consumer out-of-pocket spending.
- Medicare and private health insurance spending include premium contributions from enrollees.

Chart 6-2. Medicare's share of national spending varies by type of service, 2002



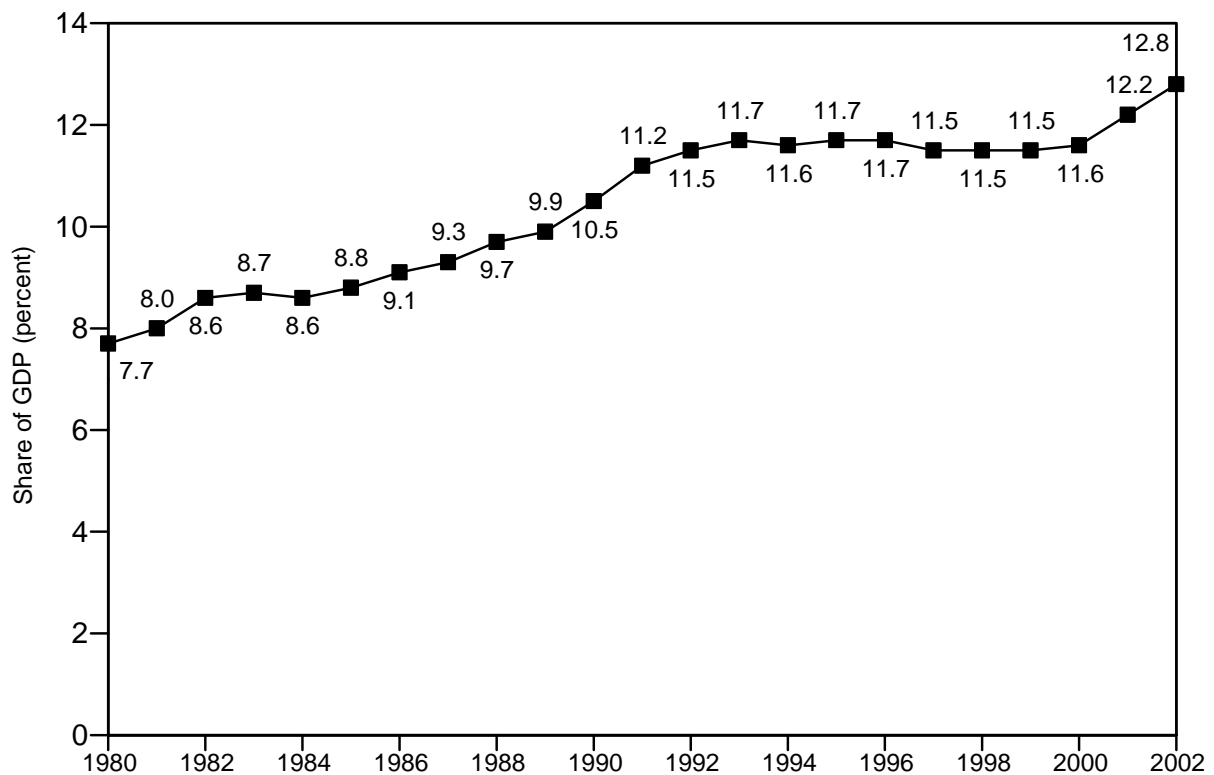
Note: SCHIP (State Children's Health Insurance Program). Personal health spending includes spending for clinical and professional services received by patients. It excludes administrative costs and profits. Totals may not sum to 100 due to rounding.

*Other includes private health insurance, out-of-pocket, and other private and public spending.

Source: CMS, Office of the Actuary, National Health Accounts, 2004.

- The level and distribution of spending differ between Medicare and other payers, largely because Medicare covers an older, sicker population, and did not cover services such as outpatient prescription drugs and long-term care during this time period.
- Medicare accounts for 30.7 and 31.6 percent of revenues for hospitals and home health agencies, respectively. In contrast, it pays for only 1.6 percent of prescription drugs and 12.5 percent of nursing home care.

Chart 6-3. Personal health care spending is increasing as a share of GDP

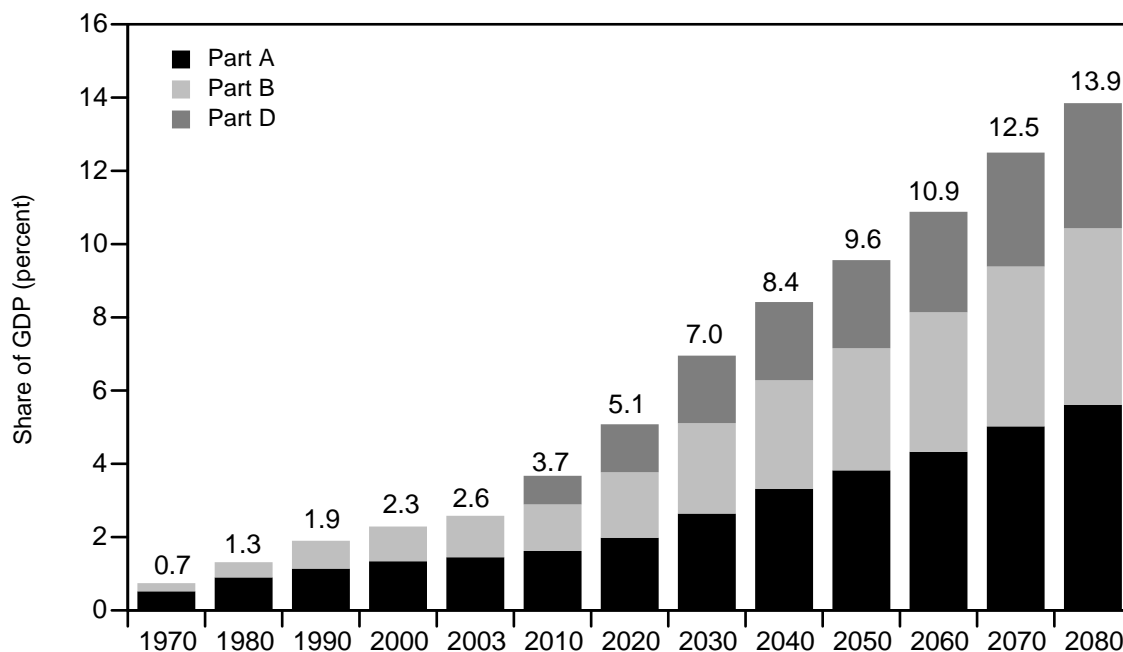


Note: GDP (gross domestic product). Personal health spending includes spending for clinical professional services received by patients. It excludes administrative costs and profits.

Source: CMS, Office of the Actuary, National Health Accounts, 2004.

- Personal health care spending consumes an increasing proportion of national resources, accounting for a double-digit share of gross domestic product (GDP) annually since 1990.
- Personal health spending as a share of GDP has increased from 7.7 percent in 1980 to a high of 12.8 percent in 2002. Stability in this proportion throughout much of the 1990s was due to slower spending growth associated with the introduction of managed care and to a strong economy.

Chart 6-4. Trustees project Medicare spending to increase as a share of GDP

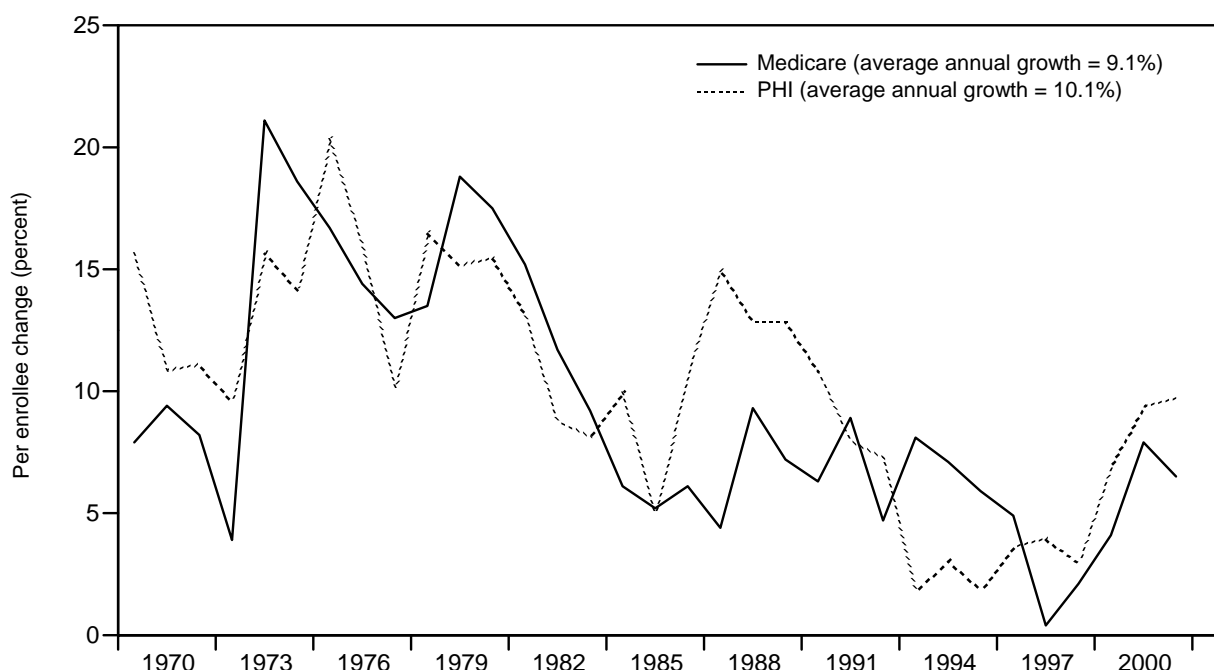


Note: GDP (gross domestic product). Trustees' data are incurred.

Source: 2004 annual report of the Boards of Trustees of the Medicare trust funds.

- Over time, Medicare spending has accounted for an increasing share of gross domestic product (GDP). From less than 1 percent in 1970, it is projected to reach 13.9 percent of GDP in 2080.
- Medicare's share of GDP increased at a faster rate in the historical period than is projected for the future. From 1980 to 2003, it grew at an average annual rate of 3.1 percent. In the projection period, Medicare's share of GDP is projected to increase steadily but at a slower pace of 2.2 percent average annual growth.
- The slower growth in Medicare's share of GDP in 2000 was due to payment reductions enacted in 1997 and faster economic growth. After 2011, the aging of the baby boom generation, an expected increase in life expectancy, and the Medicare drug benefit are expected to contribute to increases in this proportion. Additional factors such as innovation in technology also contribute to the projected rapid increases in Medicare spending as a portion of GDP.

Chart 6-5. Changes in spending per enrollee differ between Medicare and private health insurance

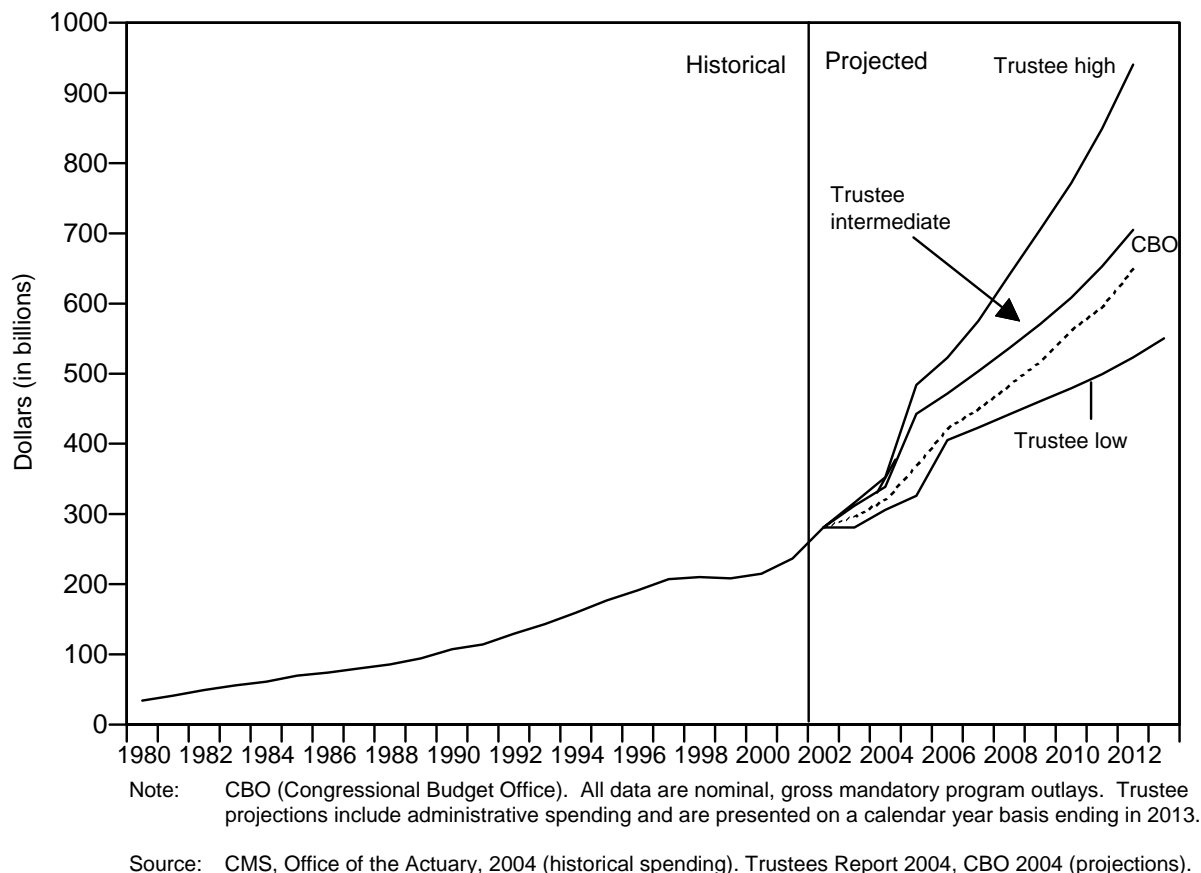


Note: PHI (private health insurance). Chart compares services covered by Medicare and PHI, including hospital services, physician and clinical services, other professional services, and durable medical products.

Source: Heffler, S., S. Smith, S. Keehan, et al. 2004. Health spending projections through 2013. *Health Affairs Web Exclusives* (February 11). <http://www.healthaffairs.org>.

- Over a 32-year period, despite some fluctuation, Medicare's average per enrollee growth rate has been slightly lower over the long term than the average for private health insurance. This may reflect the effects of the program's size and policies that hold down spending, such as the provisions in the Balanced Budget Act of 1997. After adjustment for comparable benefits, national health accounts data show that the average annual per enrollee Medicare growth over this period was 9.1 percent, compared to 10.1 percent for private health insurance.
- This comparison is imperfect, however, and should be considered with an appreciation for its limitations. Private insurers and Medicare do not buy the same mix of services, and Medicare covers an older population that tends to be more costly. For example, Medicare spending on services provided by home health agencies and skilled nursing facilities grew rapidly in the 1990s, but these services generally are a small part of benefits paid by private insurers. In addition, the data do not allow analysis of the extent to which spending trends were affected by changes in the generosity of covered benefits and, in turn, enrollees' cost-sharing burden.
- A discussion on comparing Medicare and private health insurance growth can be found in Chapter 1 of the MedPAC March 2004 Report to the Congress, available at http://www.medpac.gov/publications/congressional_reports/Mar04_Ch1.pdf.

Chart 6-6. Trustees and CBO project Medicare growth rate of about 10 percent over next 10 years

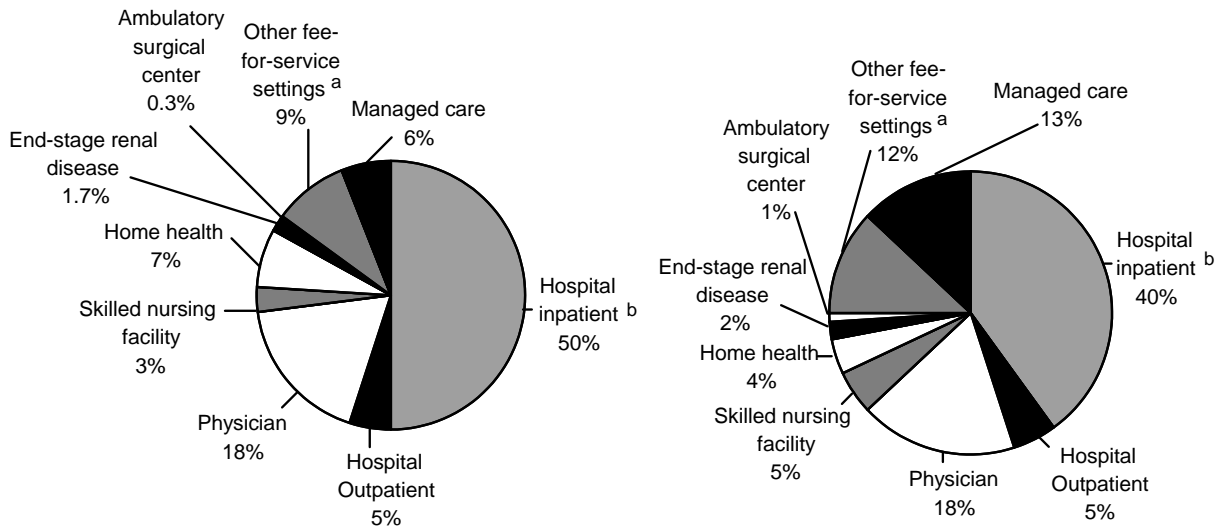


- Medicare spending has grown more than eight fold, from \$33.9 billion in 1980 to \$272.4 billion in 2003.
- Between 1980 and 1997, Medicare spending grew rapidly, increasing 11.1 percent annually on average. Following passage of the Balanced Budget Act of 1997, which reduced Medicare provider payment rates, this rate of increase declined sharply, to about 2 percent average annual growth between 1997 and 2000. Subsequent legislation restored some of the payment reductions and this, in part, accounts for spending increases of 10.1, 6.6, and 4.9 percent in 2001, 2002, and 2003, respectively.
- CBO projects that mandatory spending for Medicare will grow at an average annual rate of 10.1 percent from 2004 to 2014. The Medicare Trustees' intermediate projection for 2003 to 2013 assumes 10.8 percent average annual growth. Forecasts of future Medicare spending are inherently uncertain, and differences can stem from different assumptions about the economy (which affect provider payment annual updates) and growth in volume and intensity of services delivered to Medicare beneficiaries, among other factors.

Chart 6-7. Medicare spending is concentrated in certain services and has shifted over time

Total spending 1993 = \$143 billion

Total spending 2003 = \$272 billion



Note: Spending numbers are presented as gross outlays, meaning that they include spending financed by beneficiary premiums but do not include spending by beneficiaries (or on their behalf) for cost sharing associated with Medicare-covered services. They are reported on a fiscal year, incurred basis and do not include spending on program administration. Totals may not sum to 100 due to rounding.

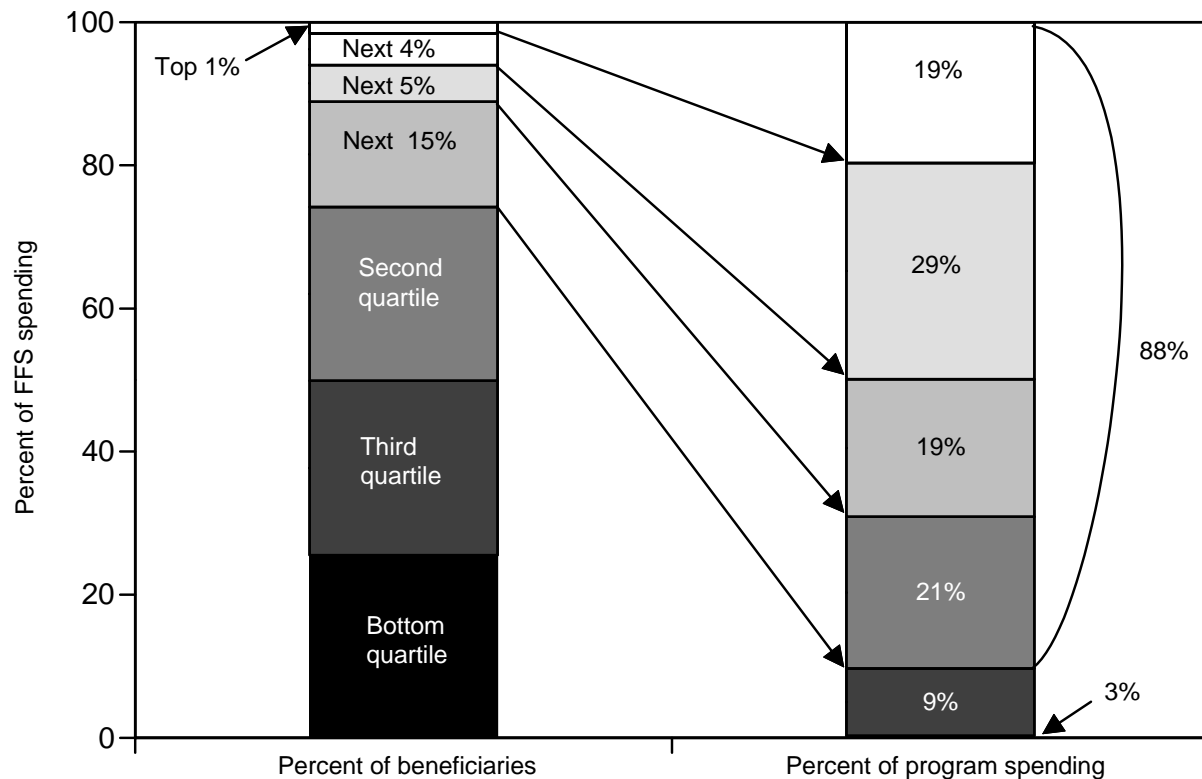
^a Includes hospice; outpatient laboratory; durable medical equipment; physician-administered drugs, ambulance service, and supplies; and rural health clinics, federally qualified health centers, and outpatient rehabilitation facilities.

^b Includes all hospitals, those paid under the prospective payment system (PPS), and PPS-exempt hospitals.

Source: CMS, Office of the Actuary, 2004 Mid-Session Review.

- Medicare spending is concentrated on certain services, and the distribution among services or settings can vary substantially over time.
- In 2003, Medicare spent about \$272 billion, or \$6,647 per enrollee. Inpatient hospital services were by far the largest spending category (40 percent), followed by physicians (18 percent), managed care (13 percent), and other fee-for-service settings (12 percent).
- Although inpatient hospital services still comprise the largest spending category, the category has shrunk as a percentage of Medicare spending, falling from 50 to 40 percent. Spending on beneficiaries enrolled in managed care has grown from 6 to 13 percent over this period. While the number of beneficiaries enrolled in managed care plans has declined recently, current enrollment remains higher than it was a decade ago.

Chart 6-8. Medicare spending is concentrated among a small group of beneficiaries



Note: FFS (fee-for-service). Reflects concentration in spending in 2002. Based on a 0.1 percent sample file of Medicare FFS beneficiaries and their claims.

Source: Direct Research, LLC.

- Medicare fee-for-service (FFS) spending is concentrated among a small number of beneficiaries. In 2002, the costliest 5 percent of beneficiaries accounted for 48 percent of annual Medicare FFS spending and the costliest quartile accounted for 88 percent. By contrast, the least costly half of beneficiaries accounted for only 3 percent of FFS spending.
- Costly beneficiaries tend to include those that have multiple chronic conditions, those using inpatient hospital care, and those who are in the last year of life.
- Further discussion of this analysis can be found in chapter 2 of the MedPAC June 2004 Report to the Congress, available at http://www.medpac.gov/publications/congressional_reports/June04_ch2.pdf.

Chart 6-9. Medicare HI trust fund is projected to be insolvent in 2019

Estimate	Year costs exceed income	Year HI trust fund assets exhausted
High	2005	2012
Intermediate	2010	2019
Low	*	2055

Note: HI (hospital insurance). Income includes taxes (payroll and Social Security benefits taxes, Railroad Retirement tax transfer), income from the fraud and abuse program, and interest from trust fund assets.

*Not available

Source: 2004 annual report of the Boards of Trustees of the Medicare trust funds. CMS, Office of the Actuary.

- The Medicare program is financed through two trust funds: The Hospital Insurance (HI) trust fund and the Supplementary Medical Insurance (SMI) trust fund. Unlike the SMI fund, the HI trust fund can be exhausted if spending exceeds revenue plus reserves. The HI trust fund is, by law, separate from general revenues. Its receipts come primarily from current payroll taxes and interest earnings on assets held by the trust fund, with the remainder from beneficiary premiums, income taxes on social security benefits, and other sources. The SMI trust fund is financed by general revenue and beneficiary premiums and cannot be exhausted.
- The financial status of the HI fund has deteriorated significantly and is projected to become insolvent in 2019 under the Trustees' intermediate estimate, seven years earlier than projected in the 2003 Trustees' report. Costs are projected to exceed tax revenues in 2010. This change results from several factors: The Medicare drug legislation, higher HI expenditures and lower payroll tax revenues in 2003 than expected, improved data on the health status of beneficiaries in HMOs, and model refinements for certain hospital payments.
- Under high cost assumptions, the HI trust fund could be exhausted as early as 2012. Under low cost assumptions, it would remain solvent until 2055.

Chart 6-10. Medicare FFS providers: Spending, supply and projected growth rates

Provider	Number of spending providers 2003	Program projection of FY 2003 (billions)
Inpatient PPS for acute-care hospitals	4,038	\$ 101.4
Other hospitals	2,019 ^a	7.9
Hospital outpatient PPS	3,958 ^b	13.0
Physicians	506,594	48.3
Skilled nursing facilities	14,918	14.7
Home health agencies	7,314	9.9
Hospices	2,454	5.9
Ambulatory surgical centers	3,735	1.8
Free-standing dialysis facilities	4,132	5.9
Outpatient clinical laboratories	183,874	5.4
Durable medical equipment suppliers	~50,000	5.6

Note: FFS (fee-for-service), FY (fiscal year), PPS (prospective payment system). Data include program spending only and do not include cost-sharing.

^aIncludes specialty hospitals such as psychiatric, rehabilitation, children's, cancer, and long-term care hospitals, as well as critical access hospitals and short-stay hospitals in Maryland.

^bDoes not include long-term, alcohol and drug abuse, and critical access hospitals, but does include psychiatric, rehabilitation, and children's hospitals that bill under the outpatient PPS.

Source: Number of providers comes from a variety of CMS database as of years 2002–2004, including the Provider of Service file; the Online Survey, Certification, and Reporting File; the standard Analytical File; the CMS data compendium; the CMS website; and unpublished CMS data.

- The most numerous Medicare providers are physicians, followed by outpatient laboratories and durable medical equipment suppliers.

Web links. National health care and Medicare spending

- The Trustees' Report provides information on the financial operations and actuarial status of the Medicare program.

<http://www.cms.hhs.gov/publications/trusteesreport>

- The National Health Accounts at CMS provide information and research on spending for health care in the U.S.

<http://cms.hhs.gov/statistics/nhe/default.asp>

- The CMS Chart series provides information on the U.S. health care system and the Medicare program spending.

<http://www.cms.gov/charts>

